Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: PRESBYTERIAN PLANO 3255 WEST PIONEER PARKWAY ARLINGTON TX 76013	MFDR Tracking #: M4-06-4895-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: LIBERTY INSURANCE CORP Box #: 28	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "We have found in this audit you have not paid the appropriate reimbursement according to the Acute Care Inpatient Hospital Fee Guideline. The guideline states that items such as implants, prosthetics, blood, pharmacy doses over $250, MRI's, CT's, etc. are to be paid *in addition* the per diem rates. You will need to reprocess those charges as you did not pay for the IMPLANTS at 25% of total charges or cost plus 10% if invoice available also PHARMACY DOSES over $250 was not paid. Because you did not give a valid denial reason on your EOB for the lack of payment, you will need to attach interest pursuant to § 413.019 of the Labor Code."

Amount in Dispute: $18,160.19

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "**Total billed charge: $19,960.06**." "**TX FS Inpatient Surgical per Diem $1,118.00 x 1 day = $1,118.00 Plus Carve outs:**

Y278 Implants # of units 3 Total billed: $7706.00
Graft delivery system Billed 1 @ 5180.00 Pd 0 (This is included in the facility fee.)

70 mm Acutrack plus screw Billed 2 @ 1263.00 = 2526.00 Pd 677.60 (actual cost plus 10% per facilities invoice.)

Total payment made for implants: $677.60

Y250 Pharmacy: # of units 30 Total billed: $838.79

Provider indicated by making a start next to Cefazolin that it was over the $250.00 mark per dose and the letter submitted states the pharmacy dose over $250.00 was not paid. Provider is not entitled to be reimbursed for pharmacy as a carve out because no single dose of medication billed was over the $250.00 mark.

Total paid for pharmacy as a carve out: $0.00

Interest was added earlier in the amount of: $4.21.

Total payment made per TX FS: $1,799.81."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Denial Code(s)	Amount in Dispute	Amount Due
6/15/2005 through 6/16/2005	Inpatient Surgery	M, Z585, F, Z695, N, X322, Z560, X598, Z989, W10, W1	$18,160.19	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

This request for medical fee dispute resolution was received by the Division on March 30, 2006. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on April 6, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

Background

1. Division rule at 28 TAC §133.307, effective January 1, 2003, applicable to disputes filed on or after January 1, 2003, sets out the procedures for health care providers to pursue a medical fee dispute.
2. Division rule at 28 TAC §134.401, effective August 1, 1997, sets out the fee guidelines for the reimbursement of inpatient hospitalizations.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 7/26/2005

   - M, Z585-The charge for this procedure exceeds fair and reasonable.
   - F, Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
   - N, X322-Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.

   Explanation of benefits dated 9/28/2005

   - M, Z585-The charge for this procedure exceeds fair and reasonable.
   - F, Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
   - Z560-The charge for this procedure exceeds the fee schedule or usual and customary allowance.
   - Z989-The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.

   Explanation of benefits dated 1/26/2006

   - W10, Z585-The charge for this procedure exceeds fair and reasonable.
   - W1, Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
   - W1, Z560-The charge for this procedure exceeds the fee schedule or usual and customary allowance.
   - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
   - Z989-The amount paid previously was less than is due. The current recommended amount is the result of supplemental payment.

Issues

1. Was this dispute filed in the form, format and manner prescribed under Division rule at 28 TAC §133.307?
2. Is the requestor entitled to additional reimbursement for inpatient surgical services per Division rule at 28 TAC §134.401?
3. Is the requestor entitled to additional reimbursement for implantables per Division rule at 28 TAC §134.401?
4. Is the requestor entitled to additional reimbursement for Pharmaceuticals per Division rule at 28 TAC §134.401?

Findings

1. Division rule at 28 TAC §133.307(e)(2)(A) requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the request does not include a copy of the medical bill(s) as submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(e)(2)(A).

   Division rule at 28 TAC §133.307(e)(2)(C) requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." The Division notes that the requestor has not listed the disputed services, or the total amount in dispute in the appropriate columns on the *Table of Disputed Services* as required by Division instructions. The Division concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(2)(C).

   Division rule at 28 TAC §133.307(g)(3)(B) requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the documentation submitted by the requestor

finds that the requestor has not provided medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(B).

2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401."

   Division rule at 28 TAC §134.401(c)(1), states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118.00."

   The hospital admission was from 6/15/2005 thru 6/16/2005; therefore, the length of stay was one day.

   Per Division rule at 28 TAC §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore, 1 X $1118.00 = $1,118.00.

3. Division rule at 28 TAC §134.401(c)(4), states "Additional reimbursement. All items listed in this paragraph shall be reimbursed in additional to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursement apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."

   Division rule at 28 TAC §134.401(c)(4)(A)(i), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278)."

   The requestor states in the position summary that "You will need to reprocess those charges as you did not pay for the IMPLANTS at 25% of total charges or cost plus 10% if invoice available…"

   The respondent states in the position summary that "**Y278 Implants # of units 3 Total billed: $7706.00 Graft delivery system Billed 1 @ 5180.00 Pd 0 (This is included in the facility fee.) 70 mm Acutrack plus screw Billed 2 @ 1263.00 = 2526.00 Pd 677.60 (actual cost plus 10% per facilities invoice.) Total payment made for implants: $677.60"**

   The Division finds that the requestor did not submit medical records or the manufacturers invoice to support additional reimbursement. As a result the amount ordered is $0.00.

4. Per Division rule at 28 TAC §134.401(c)(4)(C), states Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time."

   The requestor states in the position summary that "PHARMACY DOSES over $250 was not paid."

   The respondent states in the position summary that "**Y250 Pharmacy: # of units 30 Total billed: $838.79**

   Provider indicated by making a start next to Cefazolin that it was over the $250.00 mark per dose and the letter submitted states the pharmacy dose over $250.00 was not paid. Provider is not entitled to be reimbursed for pharmacy as a carve out because no single dose of medication billed was over the $250.00 mark.

   Total paid for pharmacy as a carve out: $0.00."

   The Division finds that the requestor did not submit medical records or documentation to support position that the cost per dose was $250.00 or greater to the hospital for any pharmaceutical provided to the claimant on the disputed dates of service. As a result the amount ordered is $0.00.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(A), §133.307(e)(2)(C), and §133.307(g)(3)(B). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

		10/26/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		10/26/2010
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.